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AUTHOR Hossain, Mian Bazle
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ABSTRACT

At the request of the government of Bangladesh the International Center for Diarrheal Disease Research, Bangladesh established the Maternal and Child Health-Family Planning (MCH-FP) Extension Project in 1982. This paper discusses: (1) the design of the MCH-FP; (2) the major characteristics of the national health and family planning program under the Ministry of Health and Population Control and its 1977 Matlab experiment; (3) the activities of MCH-FP; and (4) the Family Welfare Assistants (FWA) and their effect on contraceptive use. The studies found that families visited by female FWAs responded more favorably to contraceptive use. A 17-item reference list is included. (DJC)

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WORKER-CLIENT RELATIONS AND RELATED POLICY ISSUES IN THE BANGLADESH FAMILY PLANNING PROGRAM

Mian Bazle Hossain
University of Michigan

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I : INTRODUCTION

Priorities and directions for population policy are often the subject of controversy and debate, because critical policy issues remain unresolved by systematic research. The International Center for Diarrheal Disease Research, Bangladesh (ICDDR,B) has, therefore, undertaken a program of research addressed to broad themes in the population policy field. In 1977, the ICDDR,B launched a project in Matlab to test the hypothesis that the health and family planning program could succeed in rural Bangladesh. The impact of that experiment was dramatic and immediate : contraceptive use increased; fertility declined, child survival improved, and the effects were sustained over time (Bhatia, et al., 1980, Phillips, et al., 1982, and Chen, et al., 1983). Thus this study showed, for the first time, that the population policies of the government of Bangladesh could succeed if the services were organized carefully and completely (Phillips, et al., 1982).

With the success of the Matlab project, the Government of Bangladesh requested its extension to two additional sub-districts. Two new areas were proposed by the government to test the transferability of the Matlab experience to the public sector with the existing operational structures of the national program. The Matlab experiment has both organizational and technical characteristics that sets it apart from the national program. Though it is different from the national program, the Matlab project has contributed to its overall success in health

and family planning. At the request of the Government of Bangladesh, the ICDDR,B established a project in 1982, known as the Maternal and Child Health-Family Planning (MCH-FP) Extension Project (Phillips, et al., 1984), which works with the government health and family planning program in two sub-districts.

This paper discusses the design of the MCH-FP Extension project as well as the major characteristics of the national program and the Matlab experiment, some findings from the MCH-FP Extension Project, and its impact on population policy and the reaction of the Government of Bangladesh on those findings. Finally, this paper discusses worker-client relations and their effect on contraceptive use, and some policy issues related to worker-client contacts.

The MCH-FP Extension Project functions in two areas : the Sirajgonj sub-district of central Bangladesh and the Abhoinagar sub-district near the western border that Bangladesh shares with India. These areas were selected by the Government of Bangladesh. Matched adjacent sub-districts have been selected as comparison areas (see figure 1) (Phillips, et al., 1986).

To understand the structure and design of the MCH-FP Extension Project, it is helpful to review the design of the national program and its work system. The Ministry of Health and Population Control (MOHPC) of the Government of Bangladesh has Health and Population Control as two different divisions. The Health Division is responsible for hospital services, preventive medicine, and outreach services related to malaria control,

sanitation, immunization, and other health services. This division is staffed primarily by male workers. At the field level, domiciliary services are delivered by a cadre of male Health Assistants (HA). The Population Control Division of the ministry is responsible for family planning service delivery, and clinical services related to family planning. At the field level there are female workers (Family Welfare Assistants, FWA) assigned at a ratio of one to a population of 7,000 (Phillips, et al., 1986). Both the divisions have their own operational structure which is parallel to each other for delivering services.

In Bangladesh family planning program, the administrative and institutional constraints hamper the efforts to broaden the range of services and to improve the quality of care. Several problem areas have been identified in the literature. Workers in service delivery system are not properly and sufficiently trained and supervised (Planning Commission 1983). Supervisors are typically unclear about the nature of supervisory support (Hussain 1983). Administrative links between workers within the division are weak (Koblinsky, et al., 1984). Studies also note that logistics are not sufficient to provide comprehensive care by the worker due to the lack of supplies. There is a lack of cooperation between health and family planning workers and the quality and quantity of work performed by the worker is low. Each Union (a local government unit) has an average 3 to 4 male health workers and 3 female family planning workers but no unified supervisory system that would foster

cooperation among male and female workers. Work areas of the health workers are based on a revenue division, the so called jurisdiction line. Their work area is slightly smaller than that of the FWA.

The level of Coordination and functional integration between health and family planning does not exist (Koblinsky, et al., 1984). Recent efforts have been made to integrate the program into a health and family planning system through the standardization of job descriptions for both Health Assistants (HA) and Family Welfare Assistants (FWA). Under functional integration through standardization of job description, both FWAs and HAs are to provide household services of the nonclinical family planning methods, pills and condoms, with referrals for the clinical methods, plus distribution of ORS for diarrhea and vitamin-A capsules. In addition, FWAs are to provide follow up services to the contracepting clients and antenatal and postnatal care. The duties of the HAs also include epidemic surveillance, reporting of communicable diseases, and health and nutrition education and malaria identification (Koblinsky, et al., 1984).

The male family planning supervisor, called the Family Planning Assistant (FPA), is the immediate field level supervisor of the FWAs. One FPA is posted in a union. In theory, one FPA is responsible for directing and controlling the work of three FWAs. But, in practice, his role as supervisor is neither clearly articulated nor effectively exercised. Koblinsky and her

associates mention that the FPAs generally do not go to the field to supervise the FWA's work. Their field presence is minimal (Koblinsky, et al., 1984).

The FWA's and HA's daily work routine is composed of two major variables : travel time and interactions with the client. Travel includes time between the households of the client scheduled for that day as well as time from the worker's residence to the work site and their return home. Each FWA generally serves one ward and each HA generally serves less than a ward. A ward is the lowest administrative sub-unit of the government. A ward has an average population of 7500 according to 1986 population projection. In addition to her field work, each FWA is to attend fortnightly meetings in the sub-district Health Complex and Health and Family Welfare Center. Also, she has to be present at the satellite clinic once a week (Koblinsky, et al., 1986).

The Matlab Family Planning and Health Services Project : The Matlab Family Planning and Health Services Project (FPHSP) provides the operational model for changes that the MCH-FP Extension Project seeks to introduce in the MOHPC system. In the Matlab FPHSP, services are delivered primarily by married, contracepting, literate women who are recruited from the community, known as Community Health Worker (CHW). In general, a CHW is supposed to serve 7,200 villagers. In Matlab FPHSP each CHW is trained and equipped to visit households on a fortnightly basis. According to Phillips and his associates, operational aim

has been to maintain comparable and manageable workloads for female village workers and to assure that they can efficiently provide both MCH and Family Planning services (Phillips, et al., 1984).

Community Health Workers are grouped by blocks. There are 4 blocks, each have 20 CHW. Each CHW has two backup and supervisory systems. One system focuses on administration and community relations and the other on the technical and medical aspects of service delivery. Administrative supervision is performed by a male supervisor and two assistants. Field supervision at the block level is performed by four block supervisors.

In Matlab FPHSP, strong management control is vested in the non-medical, male supervisory staff. Decision-making is decentralized. Field supervisors have the authority to make decisions when needed and to change the system of work. Fortnightly meetings of supervisors and Community Health Workers and a management information system are designed to ensure appropriate linkages at all levels (Phillips, et al., 1984).

Differences between the program support provided under the Matlab system and the Government program are extensive. The principal distinction between the Matlab system and the MOHPC system is the relatively high density of female workers in Matlab. The Matlab project has six times the number of female workers as the Government program. This high density of workers in Matlab permits more rigorous standards of care and follow-up.

A second key distinction between the Government system and the Matlab system is that, there is no existance of separate functional divisions in the Matlab system. In the Matlab system, all domicilliary services, whether health related or family planning related, are provided by CHW and services follow a unified management design at all levels.

The MCH-FP Extension Project : The MCH-FP Extension Project is conducted jointly by the Government of Bangladesh and the ICDDR,B. The project was launched in response to a joint MOHPC-ICDDR,B review of the progress of the FPHSP in Matlab which concluded that comprehensive family planning services can have major demographic effects in rural Bangladesh. This study involved utilizing the existing staff and field resources of the MOHPC in two treatment sub-districts. The ICDDR,B is to provide training and counterpart support with the help of Matlab workers for the transfer process (Phillips 1982a). Unlike Matlab, the ICDDR,B is not providing services or special resources in the study areas of the Extension Project. Regular works are being exercised within the usual administrative constraints using existing resources. According to the project proposal, the role of ICDDR,B is to provide technical assistance in transferring service approaches to the government system through field based training. Phillips mentions that the objective of field work was to introduce a new management information system, based on the Matlab model, which includes field scheduling, record keeping, logistics, and other aspects of system support (Phillips, et al.,1982a).

The MCH-FP Extension Project has two components. First, the intervention strategy in which the ICDDR,B provides training to transfer elements of the Matlab project to the public sector. Second, a research strategy that aims to assess the efficacy of the existing program and its resources through a variety of instruments. It also assesses the operational changes introduced by the intervention and its impact on program effectiveness (Phillips, et al., 1984).

The Sample Registration System (SRS) is a longitudinal data base derived from interviews which was implemented in October 1982 for evaluating the MCH-FP Extension Project. Each round of the SRS consists of visits of teams of ICDDR,B male and female interviewers to approximately 20 percent of the households in 13 sample unions. A round is completed within 90 days during which approximately 6,800 households are visited. Mozumder and his associates mention that this system assesses the demographic impact of the health and family planning services that ICDDR,B has transferred to the government system. They also mention that it includes the longitudinal observations on the frequency of contact between health and family planning workers and village women, and the outcome of those contacted in respect to contraceptive use by clients (Mozumder, et al., 1986). It is now possible to tabulate linked and edited longitudinal data on demographic dynamics, government health and family planning worker's service statistics, and statistics on contraceptive use dynamics of village women within one month after data collection (Phillips, et al., 1986).

II : FINDINGS OF THE MCH-FP EXTENSION PROJECT

Despite operational constraints to the transfer of the Matlab FPHSP model to the MOHPC system, the MCH-FP Extension Project has achieved considerable success in implementing key strategies in the two subdistricts, and in transferirng the approaches developed in the course of field work into national policy (Phillips and Koblinsky 1984). Phillips and Koblinsky argued that their findings in the MCH-FP Extension Project suggest that female worker's exchange with clients have more pronounced effect than that of male workers. In the density analysis, Phillips and his associates found that the contraceptive use rate is higher among clients residing closer to female worker's residence. They argue that the higher prevalence rates near the female worker's residence reflect the levels of contact which would exist under higher female worker density. They also mention that the male workers' contact with the client shows no significant effect on contraceptive use (Phillips, et al., 1986).

On the basis of the existing findings in the MCH-FP Extension Project, this paper addresses the central question whether male worker-client exchanges contribute to family planning use in the national program in Bangladesh.

Since the MOHPC has recently integrated their program into a health and family planning system through the standardization of job description for both HA and FWA, it is

important to see the impact of male worker-client exchanges on contraceptive use by the client. In Bangladesh, the FWAs and the HAs are the primary link between the national MCH and family planning program and the rural women. Rahman argues that the adoption of contraception is a process that has to be stimulated, overseen and guided by some local agent (Rahman, 1984). He also argues that, a necessary condition for establishing such a process is that clients and program representatives have contact with each other.

Three month recall data of 6,500 eligible women served by 35 FWAs collected every 90 days for a year (April 1984 to March 1985) show that, of the 9,631 visits made by the female workers over the year, 19 percent resulted in no topic discussed, while nearly 60 percent involved a discussion of family planning only. Koblinsky argues that a very low proportion of female MOHPC worker visits over the year were reported to involve a tangible service to the client or a member of her family (Koblinsky, et al., 1986). The same eligible women served by the similar number of HA's collected every 90 days for a year (April 1984 to March 1985) shows that, of the 10,307 visits made by the male worker over the year, 29 percent resulted in no topic discussed, while only 0.5 percent involved a discussion of family planning only (Clark, et al., 1986).

A multiple logistic regression analysis by Phillips and his associates on the relationship between contraceptive use and travel time of the FWA from her residence to the client's home show a significant negative effect. The authors argue that the

significant negative effect suggests that higher prevalence occurs close to the FWA residence, which means distance makes difference for FWA. They also mention that the travel time of the HA from his residence to the client's home shows no significant effect on contraceptive use (Phillips, et al., 1985). Figure 2 shows that the travel time of the FWA from her residence to client's home has a pronouced impact on contraceptive use (Phillips, et al., 1985). If the travel time of FWA increases, the probability of using contraceptive methods by the client decreases.

Results from the Kanpur study show that female clients respond more favorably to the female family planning worker than they do to male workers. Misra and his associates argue that the female clients tend to be visited by female workers rather than by male workers (Misra, et al., 1982). Simmons and her associates mention that the sex of the worker is important and can influence the quality of client relation (Simmons, et al., 1986).

Approximately 14,000 HAs are working at the village level to deliver family planning services as well as health services in Bangladesh. Thus it is important to know the nature of the services they are providing. The present HA work force is slightly greater than the present FWA work force. So, there is a need of utilizing this large HA work force properly for the national family planning program.

III : SOURCE OF DATA

In this paper, the results of several methodologies are used to form a composite picture of the relation of FWA and HA with clients. They include the following :

1. A longitudinal record keeping system, the Sample Registration System (SRS), has documented worker-client contacts during a 90-day cycle since April 1984. Interviewers collect recall data on the number of visits a client has received by the worker gender, topic discussed, and services delivered in the 90 day period.

2. Travel time from FWAs and HAs residence to the client's home in their working area was estimated by knowing the distance between the client's home and their respective worker's residence, for both FWA and HA and calculating the possible travel time under optimal weather conditions considering the mode of transportion they generally use.

Since her recruitment in 1976, the FWA has become the primary link between the nationally sponsored family planning services and the eligible rural women. Because of her household visits, she is able to bring services to the client, thus overcoming the hesitation rural Bangladesh women feel in moving outside their home. Phillips and Koblinsky argue that the contact with the female worker increases the contraceptive prevalence by 3.0 points in a round (90 days cycle) if her prevalence is low (Phillips and Koblinsky 1984). When the FWA was first recruited in 1976, the average female family planning worker to population

ratio was approximately 1:6,000. In 1986, however, it was estimated 1:7,500 (see tablel 1). Koblinsky and her associates mention that the FWA has continually reduced the amount of time spent with at least some of the women in her area in order to complete her 90 days cycle, to meet her schedule to recruit new clients, to supply contraceptive methods among new and old users and to attend meetings and satellite clinics (Koblinsky, et al., 1986).

Under functional integration, since the FWA and the HA are the service provider in the government system, therefore, their role in recruiting new acceptors is an important factor in Bangladesh's plan to achieve replacement level fertility by the end of this century. In recognition of their importance, the government has stated in the Third Five Year Development Plan that 10,000 new FWAs would be recruited between 1986-1990 to join the present FWA work force of 13,500. According to Koblinsky and her associates, this recruitment of new FWA's would bring the female worker population ratio to 1:6,000 from its present 1:7,500 level (see table 1) by 1988 if the population remained at its 1986 level of 102 million (Koblinsky, et al., 1986). However, by the time all new FWAs have been recruited in 1990-91, the average worker-population ratio may reach 1:4,800 based on the projected population growth of the Bangladesh Bureau of Statistics. In the intervening years the 1:7,500 ratio will decrease slowly, and will only drop below 1:5,000 in 1990-91 (see table 1). Koblinsky and her associates argue that the density of female field workers to population can be expected to be again low for the near future.

CONCLUSION

In the Bangladesh health and family planning program, primary responsibility for family planning and maternal child health activities at the village level rests with the female worker. Findings in the MCH-FP Extension Project area suggest that worker-client relations has both a direct and an indirect impact on contraceptive use. The findings in the MCH-FP Extension Project also suggest that the female worker's exchanges with client have a pronounced effect on contraceptive use. Female workers exchanges with the clients are associated with higher contraceptive use rate than those of male workers. In the vicinity of her home, the female worker has a greater presence than in more distant areas. The results also show that male workers visit more households than female workers. The reason may be that the male workers are more mobile than the female workers. Despite the lower rate of contact between clients and female workers, their impact on contraceptive use is significant. In contrast, the higher rate of male workers contact with the clients has no effect on contraceptive use. The results also suggest that the contraceptive prevalence rate is higher among clients closer to the residence of female worker. As the distance from a female worker's residence to client's home increases the required work effort increases geometrically. Higher prevalence rates near the female worker's residence reflect the levels of contact. It is also observed that male workers rarely discuss family planning with female clients, and rarely provide family planning supplies or services to them.

The Bangladesh government's present decision to recruit 10,000 new FWAs will increase the worker density for the time being. But after a short period of recruitment, the female worker density again will decrease (see table 1). But there is a need to utilize the male worker properly by developing a new policy. We do not know the reason for the insignificant effect on prevalence by the male workers contact. We need to know the underlying reason behind this insignificant effect. Both male and female workers are the link person between the national family planning program and the rural clients.

Further research and analysis is needed in family planning. It is therefore important to understand the male worker's role in worker-client exchange and subsequent fertility behavior of clients. The MCH-FP Extension Project has already conducted a worker survey, which covers their personal characteristics and other relevant information with their work system. This worker survey data has been computerized, edited and cleaned. I think, we may understand the underlying problem associated with male workers contact and exchange with client and its relation to contraceptive use by analyzing available worker survey data, which will enhance our understanding in relevant fields, and will help to develop new policies in population programs of Bangladesh. In the future, I plan to analyze this data to broaden our understanding.

TABLE 1[a]

FWA TO POPULATION RATIO PROJECTED THROUGH 2000

Date	Population Projection[1]	No. FWAs[2]	FWA: Population
Jan.1, 1980	87,399,000	13,500	1: 6,474
Jan.1, 1986	101,720,000	13,500	1: 7,535
Jan 1, 1987	104,113,000	15,500	1: 6,717
Jan 1, 1988	106,645,000	17,500	1: 6,094
Jan 1, 1989	109,133,000	19,500	1: 5,567
Jan 1, 1990	111,706,000	21,500	1: 5,196
Jan 1, 1991	112,959,000*	23,500	1: 4,807
Jan 1, 1995	124,939,000*	23,500	1: 5,317
Jan 1, 2000	138,297,000*	23,500	1: 5,885

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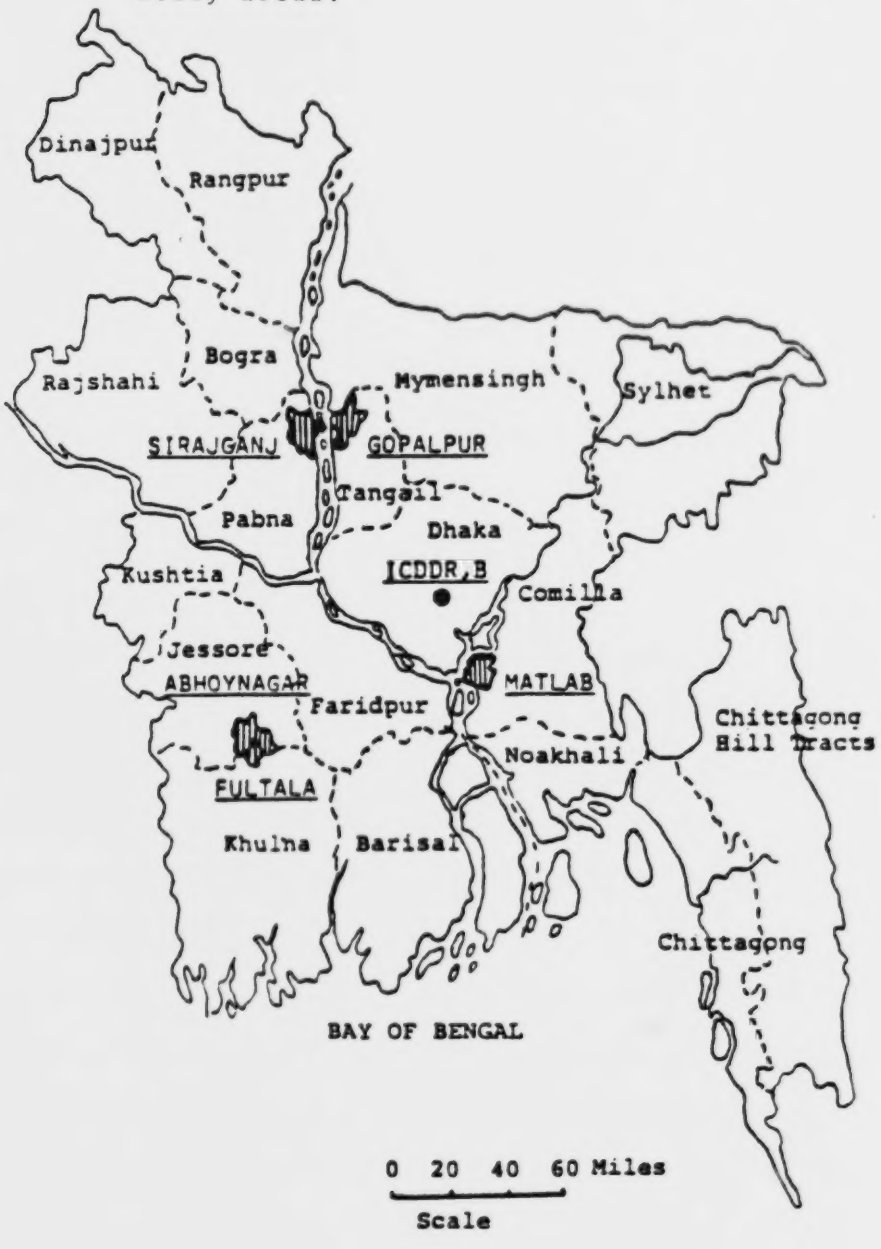
1 Source: Bangladesh Bureau of Statistics, 1984-85 Statistical Yearbook of Bangladesh, [Tables 270 (projection 2) and 271, page 141], Government of the People's Republic of Bangladesh, December 1985.

2 These numbers are based on the assumption that six months are required for the recruitment and training of FWAs.

* Interpolations from July estimates assuming a constant rate of growth.

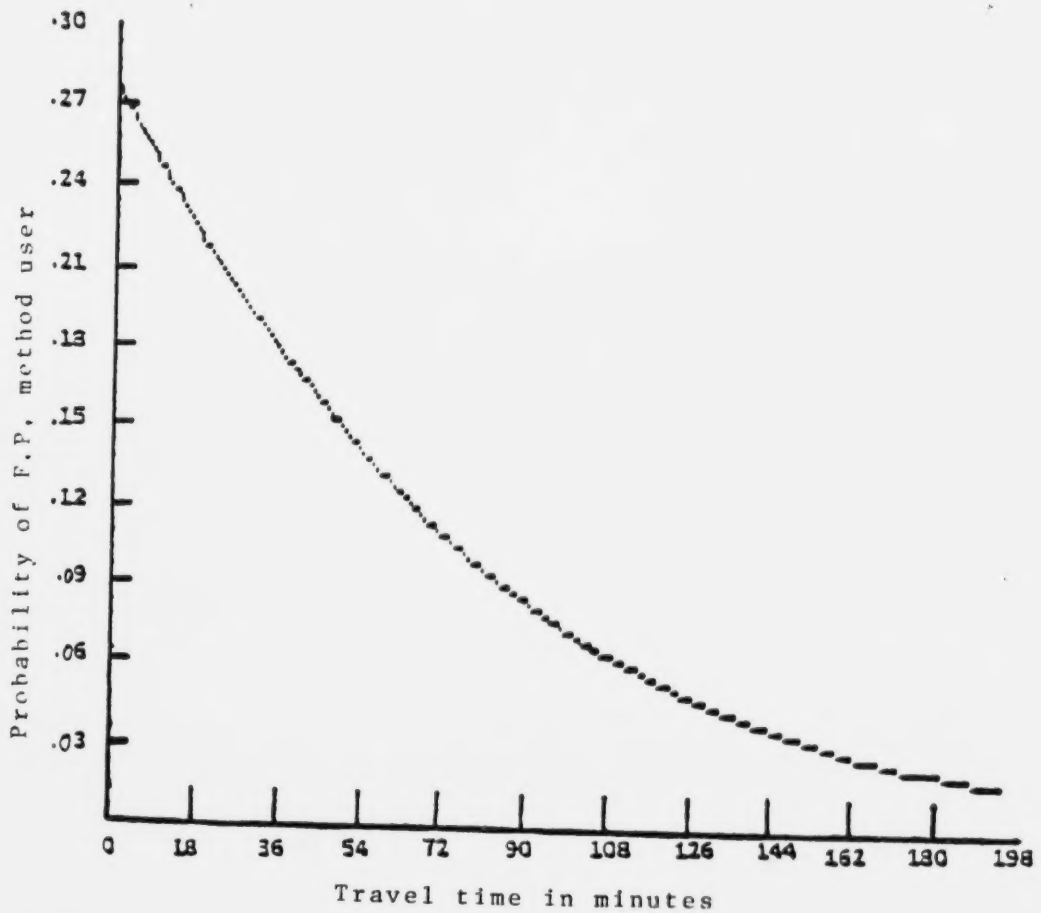
a Source : Koblinsky, M.A., Brechin, S.J.G., Clark, S., Hossain, M.B., Shaha, C., and Hasan, Y. Daily and monthly work routines of the Government Family Planning worker : The Family Welfare Assistant (FWA). Dhaka. MCH-FP Extension Project Operations Research Paper series 52, Mimeographed, April, 1986.

Figure 1 : Map of Bangladesh showing Matlab and Extension Project study areas.



a

Figure 2 : Conditional logit regression curve for the relation between contraceptive use of eligible women and travel time of FWA from her residence to client controlling for accessibility of fixed services and other types of workers.



a Source : Phillips, et al. Implementation based policy development : A progress report on the MCH-FP Extension Project paradigm, field strategy and impact, briefing paper of the ICDDR,B submitted to the Ministry of Health and Population Control (mimeographed). 1985.

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